HAB PERFORMANCE MEASURES FOR ADAP, MEDICAL CASE MANAGEMENT & ORAL HEALTH: COMPANION GUIDE

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This document is intended to explore some of the questions most frequently asked by programs that receive Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program) funds. The document focuses on questions related to the *HIV/AIDS AIDS Bureau's (HAB) Clinical Performance Measures for ADAP, Medical Case Management, and Oral Health* and will be updated as necessary.

For questions related to the core clinical performance measures, please refer to *HIV/AIDS AIDS Bureau's (HAB) HIV Core Clinical Performance Measures for Adults & Adolescents: Companion Guide* available at:
ftp://ftp.hrsa.gov/hab/habPMsGuide09.pdf

The following questions have been frequently asked and the corresponding answers are detailed in this document:

ADAP Performance Measures

MEDICAL CASE MANAGEMENT PERFORMANCE MEASURES

Oral Health Performance Measures

Data Collection & Reporting

ADAP Performance Measures

APPLICATION DETERMINATION

Question: *Should a wait list be considered when using the ADAP Application Determination measure?*

Answer: No. The measure assesses the efficiency of ADAP application determination. In order for an ADAP client to be placed on the ADAP wait list, the client's application must first be received and processed by the ADAP program. Therefore, a determination of eligibility has already been made. A wait list is a separate issue and does not influence the measure.

Question: *How should applications submitted during the last two weeks of the measurement year be handled? Are they included in the subsequent measurement year?*

Answer: Applications submitted in the last two weeks of the measurement year are excluded from the denominator. They would, however, be included in the subsequent measurement year. For example, applications submitted in the last two weeks of 2009 would be captured in a review for 2010.

Question: *What is considered a "complete application" for enrollment in the ADAP?*

Answer: The requirements for eligibility into an ADAP are determined by each program. A complete application is one that meets these requirements and enables the ADAP to enroll a client into the program.

ELIGIBILITY RECERTIFICATION

Question: *Is there a difference between reviewing a client for eligibility and "recertifying" a client for ADAP?*

Answer: Yes, there is a difference. Before a client can be accepted into the ADAP program, a client must first meet the eligibility criteria. Once enrolled, eligibility must be reassessed at least two times in the year to assure they are still eligible to receive those services. This process is known as "recertification."

Question: What type of documentation is needed for recertification?

Answer: The requirements for the initial eligibility application and recertification are determined by the ADAP program. Eligibility recertification includes verification of third party payor sources, such as Medicaid and Medicare.

Question: Why is the timeframe for recertification 150 days?

Answer: The measure focuses on recertifying clients for ADAP services at least two or more times during the measurement year. The timeframe of 150 days allows ADAP programs to conduct their recertification prior to the end of a six month interval.

FORMULARY

Question: Why are the PHS Guidelines for the Use of Antiretroviral Agents published in the last 90 days of the measurement year excluded from the sample?

Answer: In most states and jurisdictions, a more formal process is undertaken to add new medications to the ADAP formulary. To account for the time it takes to complete this process, PHS Guidelines that are published in the last 90 days of the measurement year are excluded. They would, however, be captured in the subsequent year.

Question: What if there are no new classes of drugs included in the PHS Guidelines during the measurement year?

Answer: In the event that no new classes of drugs were included, this measure would not be applicable for the measurement year.

INAPPROPRIATE ANTIRETROVIRAL REGIMEN COMPONENTS RESOLVED BY ADAP

Question: How can ADAPs identify inappropriate ARV regimen components?

Answer: In the ideal setting, mechanisms would be in place to review prescriptions for inappropriate ARV regiment components prior to being provided by the ADAP. This would potentially avoid identified suboptimal antiviral potency, unacceptable toxicities or pharmacologic concerns. If a prospective review is not available, then the ADAP is encouraged to implement a retrospective process which systematically reviews, on a routine schedule, ARV prescriptions provided by ADAP to

identify the inappropriate ARV regiment components as outlined in the PHS Guidelines "Antiretroviral Regimens or Components That Should Not Be offered At Any Time."

Question: *Our ADAP program provides only insurance coverage for prescriptions. How do we implement this measure?*

Answer: One strategy is to use the existing pharmacy utilization and safety reviews already in use by the insurance provider to identify, review and resolve inappropriate components. If the ADAP does not receive a list of medications prescribed, this measure may not be appropriate. Grantees are encouraged to talk with other programs about how they are utilizing this measure.

Question: *How do we document that the ADAP program reviewed and resolved the inappropriate regimen?*

Answer: In order to resolve the inappropriate regimen, the prescribing clinicians should be contacted by the ADAP program (or its agent) to review the regimen components and determine if the treatment should be modified or meets an exception based on clinical rationale (as specified in the PHS Guidelines). These activities should be documented in the ADAP client's record.

Question: *What criteria should we use to determine if an exception is adequately justified?*

Answer: The PHS Guidelines provide criteria for a clinical rationale for exceptions. The ADAP can also use the clinical expertise of its Medical Director or Advisory Committee, if available, or other clinical resources, such as the AIDS Education and Training Center (AETC) and the National HIV Clinician's Consultation Center to consider the case-specific rationale. The rationale should be documented in the ADAP client's record.

Question: *The exclusion criterion indicates ADAP is responsible only for the ARV medications funded by ADAP. Should we consider other information if we have it?*

Answer: It is recognized that clients may have multiple payor sources for ARVs (including public and private sources, self pay, and clinical trials). As a result, the indicator provides an exception for ADAP programs to be only responsible for identifying ARV regimen components funded by ADAP. However, if additional information is available, such as other relevant

medication history and payment source information, this information should be considered when reviewing and resolving inappropriate regimens. The goal is to ensure the safety of the patient.

Question: *Shouldn't the denominator include all ADAP ARV prescriptions? Why is this limited only to those with inappropriate antiretroviral (ARV) regimen or components?*

Answer: The measure is designed to examine the regimen components that were identified by the ADAP program as inappropriate and determine what percent were resolved by the ADAP program. If the focus of the measure was strictly on the percentage of inappropriate regimen components prescribed, then all ADAP ARV prescriptions would be included.

Medical Case Management Performance Measures

CARE PLAN

Question: *What are the recommended or required components of a medical case management care plan?*

Answer: The HIV/AIDS Bureau has not recommended or required specific components be included in a medical case management care plan. The client's individualized care plan is the plan of action written by the case manager who conducted the client's initial comprehensive assessment. The care plan should include the identified service needs, goals, objectives, desired outcomes and realistic time frames for resolution of the identified needs. The individualized care plan is developed collaboratively between the case manager and the client. Clearly defined priority areas for needed services and specific actions to be taken to meet these goals should be outlined. Medical case management includes treatment adherence counseling to ensure readiness for and adherence to complex HIV/AIDS regimens, coordination of services and monitoring of the plan to assess efficacy. These key elements should be addressed in the care plan.

The TARGET Center is a resource developed for the Ryan White Community and can be accessed at: http://careacttarget.org. This is a technical assistance source which has Case Management Standards of

Care posted for various states. These documents can be used as a guide for a grantee, provider, or case management organization to use in defining the components of a medical case management care plan that might be used in their state, region, or organization.

Question: What if the medical case management care plan didn't need to be updated?

Answer: If the care plan remains appropriate and no revisions are made, the medical case manager should document that the care plan has been reviewed and no changes were indicated. While not required, it is strongly recommended that clients indicate either acceptance or review of their care plan, regardless of whether changes were made.

Question: Are clients required to indicate their acceptance and/or review of their medical case management care plan?

Answer: While it is strongly recommended that clients indicate either acceptance or review of their care plan, it is not required by HAB.

Question: Is a medical case management care plan required for clients receiving "low intensity" medical case management services or for patients with lower acuity?

Answer: Yes. All clients receiving medical case management services, regardless of the level of acuity, should have a care plan established.

Question: Do the outcome measures apply only to patients receiving medical case management services, or can they be used for the broader HIV/AIDS patient population?

Answer: Yes. The outcome measures may be used, as appropriate, for the broader HIV/AIDS patient population.

MEDICAL CASE MANAGEMENT: MEDICAL VISITS

Question: What type of documentation in the medical case management record of a patient's medical visit is acceptable? Is self-report acceptable?

Answer: No, self report is not acceptable. Examples of documentation include communication between case manager and provider, progress notes that document the day of visit to provider or case conference notes. Even if medical and case management services are co-located, the case

management record should clearly document the medical visit. The information could be accessed through medical records or electronic health records.

Question: Why does the medical case management medical visit measure focus on the case manager's documentation, rather than on the services that the patient needs and receives?

Answer: Documentation of the client's medical visit by the case manager indicates the active involvement of the case manager in the client's successful utilization of and retention in medical care, which is the focus of this performance measure. While this measure is similar to the HAB clinical measure, "Medical visits", the difference is in the source of data.

Oral Health Performance Measures

Question: Within the Ryan White community, which providers should use the oral health performance measures?

Answer: The measures are designed to be used by dental providers providing oral health services for the HIV-infected population.

Question: How should we use the American Dental Association Current Dental Terminology (ADA CDT) billing codes?

Answer: The ADA CDT codes included in the detail sheets are provided as examples to help identify potential data sources. The list is not meant to be exhaustive.

Question: How can the data be collected if ADA CDT Code data are not available for a specific procedure or if the oral health provider does not use ADA CDT Codes for billing or documentation purposes?

Answer: If ADA CDT codes are not used, data can be abstracted from patient charts to determine if a service has been provided. "Dummy" codes can also be utilized to capture the required data and allow for analysis using electronic datafiles.

PHASE I DENTAL TREATMENT PLAN COMPLETION

Question: What should be included in a Phase I Treatment Plan?

Answer: Phase I treatment focuses on the prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. Treatment could be restorative or include basic periodontal therapy (non-surgical) or simple extractions and biopsy. It could also include non-surgical endodontic therapy, such as root canals or space maintenance and tooth eruption guidance for transitional dentition (non-orthodontic).

Question: What if we don't have the clinical capacity/resources to complete the Phase I treatment plans?

Answer: It is understood that access to dental services is challenging in certain geographic regions. It is, however, important to document the services that are being provided in light of constrained resources. The data should reflect the percentage of Phase I treatment plans that were able to be completed.

Question: What if the treatment plan changes during the course of the year due to increasing complexity or patient needs? Should we readjust the 12 month initiation date of the treatment plan?

Answer: No, the initiation date should not be changed. The chart should reflect the status of each activity outlined in the treatment plan. If new services are required, these would be captured in the treatment plan for the subsequent year.

Question: Should the dental treatment plan and the Phase I dental treatment plan performance measures be used together?

Answer: Yes, it is recommended that these measures be used in tandem as a way to measure care.

Data Collection & Reporting

Question: Will CAREWare be updated to include data elements for all new measures?

Answer: To the extent possible, new performance measures are being incorporated into CAREWare. Because of the complexity of some of the measures, not all can be incorporated.

Question: Will information submitted for the Ryan White Program Services Report (RSR) provide the data for the HAB performance measures?

Answer: The information submitted for the RSR will provide data directly on point for some of the performance measures, but not all. In those instances, additional information may need to be obtained through other data reporting systems, patient registries or record reviews.